North Dakota Department of Health
Division of Disease Control
SFN 18385 (06/06)

Clinic Identification Number

Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

Patient's Name (Last, First, Middle Initial)	Date of Birth	Age	Gender (circle) Male Female

Name of Parent or Guardian Responsible for Patient	Relationship to Patient

Address (Street or P.O. Box)	City	County	State	Zip Code

Home Telephone Number	Work Telephone Number	E-mail Address (optional)

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

Signature – Person to receive vaccine or person authorized to sign on the patient's behalf:

X **Date:**

VFC Eligibility Status (Check all that apply): This section must be completed.

□ Native American □ Medicaid Eligible □ No Insurance □ Underinsured, vaccines not covered by health insurance
□ Insured, vaccines covered by health insurance (not VFC eligible)

If insured or underinsured, Name of Insurance Company_____

Policy # _____ (Must be entered into NDIIS)

✓	Vaccine(s) To Be Given	Route[1]	VIS Date	Manufacturer[2] (circle)	Lot Number	Admin. Site[3] (circle)	Exempt[4]
	DT (pediatric diphtheria-tetanus)	IM	7/30/01	AVP		LA RA LT RT	
	DTaP (diphtheria-tetanus-pertussis)	IM	7/30/01	AVP GSK		LA RA LT RT	
	DTaP/HepB/IPV (Pediarix™)	IM	7/30/01 7/11/01 1/01/00	GSK		LA RA LT RT	
	DTaP/Hib Combination	IM	7/30/01 12/16/98	AVP		LA RA LT RT	
	Hep A (hepatitis A)	IM	3/21/06	MSD GSK		LA RA LT RT	
	Hep B (hepatitis B)	IM	7/11/01	GSK MSD		LA RA LT RT	
	HBIG (hepatitis B Immunoglobulin)		n/a	BAY		LA RA LT RT	
	Hib (*Haemophilus influenzae* B)	IM	12/16/98	AVP MSD		LA RA LT RT	
	HPV (Human Papilloma Virus)	IM		MSD		LA RA LT RT	
	Influenza	IM/IN				LA RA LT RT	
	IPV (inactivated polio vaccine)	IM/SQ	1/01/00	AVP		LA RA LT RT	
	MMR (Measles-Mumps-Rubella)	SQ	1/15/03	MSD		LA RA LT RT	
	MMRV (MMR-Varicella)	SQ	1/15/03 12/16/98	MSD		LA RA LT RT	
	Meningococcal Conjugate (Menactra®)	IM	10/7/05	AVP		LA RA LT RT	
	Meningococcal Polysaccharide	SQ	10/7/05	AVP		LA RA LT RT	
	Pneumococcal Conjugate (Prevnar™)	IM	9/30/02	WAL		LA RA LT RT	
	Pneumococcal Polysaccharide	IM/SQ	6/10/94	MSD		LA RA LT RT	
	Rotavirus	PO	4/12/06	MSD			
	Td (tetanus-diphtheria)	IM	6/10/94	AVP MBL		LA RA LT RT	
	Tdap (tetanus-diphtheria-pertussis)	IM	5/31/06	AVP GSK		LA RA LT RT	
	Varicella (chickenpox)	SQ	12/16/98	MSD		LA RA LT RT	
						LA RA LT RT	

Signature and Title of Person Administering Vaccine **Date Administered**

X _____

1. **Route:** IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
2. **Manufacturer:** AVP = sanofi pasteur (aventis), BAY = Bayer Corporation, GSK = GlaxoSmithKline, MBL = Massachusetts Biological Laboratories, MSD = Merck & Co., WAL = Wyeth
3. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. **Exemption or Contraindication:** MED = Medical, REG = Religious, PHIL = Philosophical, MOR = Moral, HOD = History of Disease (Please indicate date of exemption, contraindication or disease)